Department of Human Resources
Division of Health Care Financing & Policy
Meeting for Public Comment on Review
Of Nevada Medicaid Services Manual and
Medicaid Operations Manual
October 26, 2004

Minutes

Attendees:

In Carson City, NV
Charles Duarte, Administrator, DHCFP
John Liveratti, Chief, DHCFP, Compliance
Darrell Faircloth, DAG
Others in attendance shown on attached lists.

In Las Vegas, NV:
Selena Burton, DHCFP, Facilitator

The meeting was called to order by John Liveratti, Chief Compliance at 9:00am in Room 2135 of the Legislative Building in Carson City, Nevada. The meeting was aired by video-conference to Las Vegas simultaneously. Those in attendance are on the attached lists from both locations.

Coleen Lawrence, Chief of Program Services, introduced MSM Chapter 1300-Durable Medical Equipment. There were multiple issues for discussion in this Chapter.

1303.12 Removes the prior authorization requirement for enteral services if the recipient has a gastrostomy tube. Ms. Lawrence requested a continuance on this issue as the system changes were not completed as of this time.

Mr. Liveratti responded that it was acceptable to do so.

The next item of discussion was Respiratory Therapy Equipment. She was requesting the addition of the ABI Vest back into the Chapter. It was in our old policy and was left out during the Chapter revisions.

Appendix B – Apnea Monitors – Language added to clarify an apnea monitor is not covered with an E0454 Ventilator. This is a clarification that an apnea monitor is not a reimbursable service in conjunction with and E0454 pressure ventilator with pressure control support and flow triggering features. This is because it is a duplicate of service.

Appendix B – Oximetry Rental – Language added to allow for reimbursement of an oximeter if the recipient is ventilator dependent, or has a tracheostomy. We are adding oximeter rentals as a covered service if the recipients meet the criteria in the Chapter. We used to have them as a non-covered service and we put the rental back in.

Mr. Liveratti asked if there were any question. He then requested Ms. Lawrence show where the information on the ABI Vest was located.

Ms. Lawrence responded that the information was in the very back of the Chapter in Appendix A. She also added that this addition is consistent with what policy had been in the past.

Public comment was invited. There were no comments from Carson City. There were two individuals who had comments from Las Vegas.

Jan Franklin, Reimbursement Supervisor for Option Care indicated that they are happy to see these changes, especially with the enteral. She said that they are still having problems the changes that were made last year, specifically concerning the low profile g-tubes; they are unable to get compensation for them. She has talked with Jeff Shaw at First Health trying to come up a solution; be it a PAR or a method to get reimbursed for the low profile g-tubes and also the extensions that go along with them.

Mr. Duarte had a question with respect to the low profile g-tubes. Were they related to the changes for the removal of the prior authorization for the enteral services and the gastrostomy tube?

Ms. Franklin responded that previously PARs were not required for children with g-tubes and there was a methodology for reimbursement for the low profile tubes. With the Medicare standards, adults don't get the low profile tubes; so the reimbursement for a g-tube is less than half what the tube costs. She stated they had an example of the difference between children versus adults and it is an area that is not being addressed by the State Medicaid program when adopting Medicare guidelines.

Mr. Duarte asked staff if we have identified some of these separate pediatric needs in our current policies or are we going to address these needs in our future policies.

Ms. Lawrence responded that right now HIPPA has adopted only one code for reimbursement of g-tubes and we took the Medicare fee schedule. What the providers are saying is that fee schedule is not adequate for the reimbursement for pediatric g-tubes, whereas HIPPA doesn't distinguish between the adult and pediatric tubes, so this is a reimbursement issue and is not in the policy. Regarding the first part of the issue, is that previously a PAR was required for a g-tube and that is what we are trying to get removed. The system is not ready for that yet and that is why requested a continuance on that part.

Mr. Duarte asked if it were possible to establish a separate set of codes with separate rates for the pediatric issues.

Ms. Lawrence responded that this wasn't part of the issue being addressed in the policy but that meetings with staff and providers could be held to look into the reimbursement issues.

The second individual from Las Vegas was Pam Wagner, Registered Dietician. Ms. Wagner explained the cost difference between an adult and a pediatric g-tube. Right now providers are receiving not quite $40 for a $90 pediatric g-tube.

Mr. Duarte thanked both ladies for their comments. He pointed out that the changes to the Chapter and the Section under discussion are not related to the reimbursement issue that had been addressed by both Ms. Franklin and Ms. Wagner. Mr. Duarte asked Ms. Lawrence and staff to discuss and try to provide a solution to the reimbursement issues for pediatric enteral needs.

Ms. Lawrence recommended the submission of a rates appeal. There needs to be documentation that line up the differences between the cost of adult and pediatric care; this appeal would need to be sent to the Rates Unit.

Mr. Duarte suggested giving the providers some guidance as to who to contact in the Rates Unit regarding the appeal and what the process for submittal might be. He indicated that there would eventually need to be a change made to the Chapter to reflect the differences between adult and pediatric enteral care. Mr. Duarte would like to see both things happen simultaneously; the submission of the appeal to deal with this issue in the interim and work on changes to the Chapter to deal with the issue on a permanent basis.

Mr. Liveratti asked for any other public comments on this issue.

There were no further comments from Carson City or Las Vegas.

Mr. Liveratti recommended approval of the changes regarding apnea monitors and oximetry rental as submitted and delay Section 1303.12 until the programming can be updated to support the policy and at that time we will give notice that the public hearing will continue on that Chapter.

Mr. Duarte accepts the changes as recommended with the exception of Section 1303.12 which will be added to the next public agenda for public hearing. The accepted changes will be submitted for a final spelling and grammar check.

Betsy Aiello, SSPS III, Waivers Unit, introduced the Adoption of Waiver for Independent Nevadans (WIN) Service Need Screen Form. The WIN Service Need Screening Form has been utilized in draft format for the last three years and is being submitted for finalization. This form is used to help determine if a person would be eligible for the waiver program if a slot was available, and therefore eligible for placement on the waiver wait list.

Ms. Aiello introduced the Adoption of WIN Monthly Telephone Contact Form. The WIN Monthly Telephone Contact Form has been utilized in draft format for the last two years and is now being submitted for finalization. The waiver program requires monthly case management contacts with recipients that include monitoring and documenting the quality of care provided to ensure the recipient's safety and health. This form guides the case manager to cover and document the issues that ensure the recipient is getting and is satisfied with the necessary services to ensure their health and safety.

Ms. Aiello introduced the Adoption of WIN Home Visit Worksheet. The WIN Home Visit Worksheet has been utilized in draft format for the last two years and is now being submitted for finalization. The waiver program requires a face-to-face home visit be completed at least every six months or more frequently if there is a concern or change in health care or safety issues. This home visit includes monitoring and documenting the quality of care provided to ensure the recipient's safety and health. This form guides the case manager to cover and document the issues that ensure the recipient is getting and is satisfied with the necessary services to ensure their health and safety.

Ms. Aiello introduced the Adoption of Physician Health Care Provider Authorization Form and Physician's Letter of Explanation. The Physician Health Care Provider Authorization Form (NMO-3428A) is an existing form which is being updated with the following changes:

4. I authorize these services to continue until _____, at which time I wish to have my patient's condition re-evaluated by myself or _____.

7.b. My patient becomes unable to self-direct the services/care authorized;

Along with NMO-3428A, is the Physician's Letter of Explanation. This is a new letter used to inform physicians authorizing skilled services by unskilled providers of their responsibilities. It identifies the NRS statute that governs the program and provides some detail as to what this program entails. This letter should always be accompanied by NMO-3428A.

Darrell Faircloth, DHCFP, DAG, had a question. Our Physician Health Care Provider Authorization Form is indicative of a physician model type service as opposed to the general State Plan services we offer. Does our waiver reflect this is truly a physician directed model?

Ms. Aiello responded that is only one part of the services offered under the waiver, this portion is a physician directed or health care provider model.

Public comment was invited. There were no public comments from Carson City or Las Vegas.

Mr. Liveratti recommended approval of the WIN Service Need Screen form, the WIN Monthly Telephone Contact form, the WIN Home Visit Worksheet and the changes to the Physician Health Care Provider Authorization form and the Physician's Letter of Explanation as submitted.

Mr. Duarte accepted the changes to the forms and letters as submitted subject to a final spelling and grammar check.

Mr. Liveratti asked for any general public comments.

Pamela Humphrey, Clark County Juvenile Justice Services, had a question about target case management and Medicaid HMO claims. Juvenile Justice has claims for submission but would like to know if and when to submit these claims for payment.

Mr. Duarte asked if they were a participating provider with the HMO?

Ms. Humphrey indicated they were.

Mr. Duarte asked if Juvenile Justice had a signed contract with the HMO.

Ms. Humphrey indicated they did not have a contract at this time.

Mr. Duarte indicated that for them to be reimbursed for their services they would need to have a contract with the HMO. The first step toward a remedy would be to contact the HMO to become a provider. He also informed Ms. Humphrey that we pay the HMO for case management, not necessarily target case management but primarily for medical case management. Mr. Duarte then asked if the children were in fee-for-service Medicaid as well.

Ms. Humphrey indicated that some of them are.

Mr. Duarte informed Ms. Humphrey that if Juvenile Justice was a participating Medicaid provider, they could bill Medicaid assuming the children were eligible. He proceeded to ask Ms. Humphrey what the circumstances of the children were; whether in a public institution or not.

Ms. Humphrey said they were not.

Sue Gonzalez, Clark County Juvenile Justice Services, spoke to help answer this question. She indicated that previously they had been able to bill Medicaid for the children's monthly visits with their supervising probation officer. These were

the particular cases they were worried about. In the past they had always been reimbursed for them and this is something that just recently came up.

Mr. Duarte indicated that he would prefer to address this issue off the record as it was not initially on the agenda. If they would see Selena Burton for contact information for his office, he would be more than happy to set up a meeting or teleconference with them to address this issue.

Mr. Duarte did address the initial first part of the question being, the responsibility of the HMO. Should the child have medical needs that require case management, the HMO is responsible. The other part of the issue, determining to what extent the services Juvenile Justice provide overlap with what the HMO is being paid contractually to provide will need to be addressed in future meetings.

Mr. Liveratti asked if there were any other questions or comments on this topic.

Ms. Humphrey indicated that Mr. Duarte had answered their questions and they would be in touch with his office to schedule a meeting.

Mr. Liveratti asked Selena Burton if there were any other questions or comments from Las Vegas.

Ms. Burton said there were none.

The agenda completed, Mr. Liveratti adjourned the public hearing at 9:32am with the notation that Section 1303.12 of Chapter 1300 will be added to the agenda for the next public hearing.